

§ 424.56

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the person authorized to request payment on the beneficiary's behalf assigns the claim to the supplier and the supplier accepts assignment.

(b) In accepting assignment, the supplier agrees to the following:

(1) To accept, as full charge for the service, the amount approved by the carrier as the basis for determining the Medicare Part B payment (the reasonable charge or the lesser of the fee schedule amount and the actual charge).

(2) To limit charges to the beneficiary or any other source as follows:

(i) To collect nothing for those services for which Medicare pays 100 percent of the Medicare approved amount.

(ii) To collect only the difference between the Medicare approved amount and the Medicare Part B payment (for example, the amount of any reduction in incurred expenses under §410.155(c), any applicable deductible amount, and any applicable coinsurance amount) for services for which Medicare pays less than 100 percent of the approved amount.

(3) Not to charge the beneficiary when Medicare paid for services determined to be "not reasonable or necessary" if—

(i) The beneficiary was without fault in the overpayment; and

(ii) The determination that the payment was incorrect was made by the carrier after the third year following the year in which the carrier sent notice to the beneficiary that it approved the payment.

[53 FR 6634, Mar. 2, 1988, as amended at 63 FR 20130, Apr. 23, 1998]

§ 424.56 Payment to a beneficiary and to a supplier.

(a) Conditions for split payment. If the beneficiary assigns the claim after paying part of the bill, payment may be made partly to the beneficiary and partly to the supplier.

(b) Payment to the supplier. Payment to the supplier who submits the assigned claim is for whichever of the following amounts is less:

(1) The reasonable charge minus the amount the beneficiary had already paid to the supplier; or

(2) The full Part B benefit due for the services furnished.

(c) Payment to the beneficiary. Any part of the Part B benefit which, on the basis of paragraph (b) of this section, is not payable to the supplier, is paid to the beneficiary.

(d) Examples.

Example 1. An assigned bill of \$300 on which partial payment of \$100 has been made is submitted to the carrier. The carrier determines that \$300 is the reasonable charge for the service furnished. Total payment due is 80 percent of \$300 or \$240. Of this amount, \$200 (the difference between the \$100 partial payment and the \$300 reasonable charge) is paid to the supplier. The remaining \$40 is paid to the beneficiary.

Example 2. An assigned bill of \$325 on which partial payment of \$275 has been made is submitted to the carrier. The carrier determines that \$275 is the reasonable charge for the services. Total payment due is 80 percent of \$275 or \$220. The \$220 is paid to the beneficiary, since any payment to the supplier, when added to the \$275 partial payment would exceed the reasonable charge for the services furnished.

[53 FR 6641, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

§ 424.57 Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing numbers.

(a) Definitions. As used in this section "DMEPOS" is the acronym for durable medical equipment, prosthetics, orthotics and supplies. A "supplier" is an entity or individual, including a physician or part A provider, which sells or rents part B covered items to Medicare beneficiaries and which meets the standards in paragraph (c) of this section.

(b) Medicare pays for items furnished by a supplier with a billing number to the—

(1) Supplier if the beneficiary (or the person authorized to request payment on the beneficiary's behalf) assigns the claim to the supplier and the supplier accepts assignment;

(2) Beneficiary, if the supplier does not accept assignment; or

(3) Partly to the beneficiary and partly to the supplier, if the supplier accepts assignment of the bill, as described in § 424.56.

(c) Medicare does not issue a billing number to a supplier that submits claims for items listed in § 421.210(b) of this subchapter until that supplier

meets, and certifies that it meets, the following standards. The supplier—

(1) In response to orders which it receives, fills those orders from its own inventory or inventory in other companies with which it has contracted to fill such orders or fabricates or fits items for sale from supplies it buys under a contract;

(2) Is responsible for delivery of Medicare covered items to Medicare beneficiaries;

(3) Honors all warranties express and implied under applicable State law;

(4) Answers any questions or complaints a beneficiary has about the item or use of the item that was sold or rented to him or her, and refers beneficiaries with Medicare questions to the appropriate carrier;

(5) Maintains and repairs directly or through a service contract with another company, items it has rented to beneficiaries;

(6) Accepts returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and/or sold) from beneficiaries;

(7) Discloses consumer information to each beneficiary with whom it does business which consists of the supplier standards to which it must conform;

(8) Complies with the disclosure provisions in § 420.206;

(9) Complies with all applicable State and Federal licensure and regulatory requirements;

(10) Maintains a physical facility on an appropriate site; and

(11) Has proof of appropriate liability insurance.

(d) If a supplier is found not to meet the standards in paragraph (c) of this section, its billing number is revoked, effective 15 days after the entity is sent notice of the revocation. A billing number may be issued, with the concurrence of HCFA, when a supplier has successfully completed a corrective action plan rectifying past violations of the supplier standards and provided sufficient assurance that it will comply with the supplier standards in the future. Corrective action includes repayment of monies due to beneficiaries

and Medicare, and honoring applicable warranties.

(e) Suppliers must renew their applications for a billing number 3 years after the billing numbers are first reissued, except for the first reissuance process, as follows: suppliers must renew applications for supplier numbers 2 years after initial issuance of billing numbers for one third of all suppliers. Another one third of suppliers must reapply 3 years after initial issuance. The last third of suppliers must reapply 4 years after initial issuance. Thereafter, each supplier must reapply 3 years after its last number is issued, unless no claim for an item furnished by a supplier has been submitted for four consecutive quarters, in which case the supplier must submit a new request for another billing number.

(f) Suppliers are required to have complaint resolution protocols to address beneficiary complaints which relate to the supplier standards in paragraph (c) of this section and to keep written complaints and related correspondence, and any notes of actions taken in response to written or oral complaints. Failure to maintain such information may be considered evidence that supplier standards have not been met. If a carrier determines that a supplier is not satisfactorily responding to one or more beneficiary complaints, the carrier may require that a supplier maintain the following information on all written and oral beneficiary complaints, including telephone complaints, it receives: The name, address, telephone number and health insurance claim number of the complainant, a summary of the complaint and the date it was made; the name of the person taking the complaint, a summary of any actions taken to resolve the complaint; and, if an investigation was not conducted, the name of the person making the decision and the reason for the decision.

[57 FR 27308, June 18, 1992, as amended at 60 FR 63444, Dec. 11, 1995]